



MedHealth Review, Inc.

661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 4/6/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a lumbar transforaminal ESI L4/5 bilateral.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a lumbar transforaminal ESI L4/5 bilateral.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant has a date of birth of xx/xx/xx. An injury was reported on xx/xx/xx and there is no description. She had back pain requiring surgery. She had injection of the hardware at L4/5 and L5/S1 in 2012. She continues to have LBP radiating to bilateral lower extremities. She is prescribed Voltaren and zanaflex. She does have hypertension.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The ODG does recommend ESI as a possible option for short term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis although ESIs have not been found to be as beneficial a treatment for the latter condition. The criteria include that 1. Radiculopathy must be documented objectively. 2. Condition should be initially unresponsive to conservative treatment.

This request does not meet the ODG criteria an epidural steroid injection. Although ESI is recommended for radicular pain, objective evidence of radiculopathy is not documented. The lower extremity pain is not documented in a dermatomal pattern. There is no EMG to support radiculopathy. The MRI does not support radiculopathy. Therefore, the requested procedure is not medically necessary at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)